DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 — 2 2

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 16, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $61,550
b. FFY 2005 $61,550

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pages 2, 3, 12, 17 & 18
Pg. 2A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, pages 2, 3, 12, 18 17and 18

10. SUBJECT OF AMENDMENT: Revised to allow for DSH payments up to 175% of the unreimbursed costs and uninsured costs for public hospitals in SFY 2004 and 2005.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT EO ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Steve Roling

14. TITLE:
Director

15. DATE SUBMITTED:
December 19, 2003

16. RETURN TO:
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 22 2003

18. DATE APPROVED: JUL - 8 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: DEC 16 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS: Per verbal change, addition of page 2a block #8

FORM HCFA-179 (07-92)

Instructions on Back

3. Disproportionate share reimbursement - The disproportionate share payments described in sections XVI and XVII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection VI.A.1 and 2 and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation. These Safety Net and Uninsured Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured unless otherwise permitted by federal law.

Revised 6/2004

4. Medicaid Add-Ons– Medicaid Add-Ons are described in sections XV, XVIII and XX and are in addition to Medicaid per-diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment– The payments described in subsection XVI are paid in lieu of Direct Medicaid Payments described in section XV and Uninsured Add-Ons described in subsection XVII.B.

II. Definitions.

A. Allowable costs. Allowable costs are those related to covered Medicaid services defined as allowable in 42 CFR chapter IV, part 413, except as specifically excluded or restricted in 13 CSR 70-15.010 or the Missouri Medicaid hospital provider manual and detailed on the desk reviewed Medicaid cost report. Penalties or incentive payments as a result of Medicare target rate calculations shall not be considered allowable costs. Implicit in any definition of allowable cost is that this cost is allowable only to the extent that it relates to patient care; is reasonable, ordinary and necessary; and is not in excess of what a prudent and cost-conscious buyer pays for the given service or item.

B. Bad debt - Bad debts should include the costs of caring for patients who have insurance but are not cover the particular services, procedures or treatment rendered. Bad debts should not include the cost of caring for patients whose insurance covers the given procedures but limits coverage. In addition, bad debts should not include the cost of caring for patients whose insurance covers the procedure although the total payments to the hospital are less than the actual cost of providing care.

C. Base cost report–Desk-reviewed Medicare/Medicaid cost report from the fourth prior year. If a facility has more than one (1) cost report with periods ending in the fourth prior year, the cost report covering a full twelve (12) month period ending in the fourth prior year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the fourth prior year will be used.

Any changes to the desk reviewed cost report after the Division issues a final decision on assessment or payments based on the base cost report will not be included in the calculations.

D. Charity Care - results from a provider's policy to provide health care services free of charge or a reduction in charges because of the indigence or medical indigence of the patient.

E. Contractual allowances–Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements.

F. Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report.

G. Critical Access. Hospitals which meet the federal definition found in section 1820(c)(2)(B) of the Social Security Act. A Missouri expanded definition of critical access shall also include hospitals which meet the federal definitions of both a rural referral center and sole community provider and is adjacent to at least one county that has a Medicaid eligible population of at least thirty percent (30%) of the total population of the county or hospitals which are the sole community hospital located in a county that has a Medicaid population of at least thirty percent (30%) of the total population of the county.

H. Disproportionate Share Reimbursement. The disproportionate share payments described in sections XVI and XVII.B include both the federally mandated reimbursement for hospitals which meet the federal requirements in Subsection V.A.1 and 2 and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation. These Safety Net and Uninsured Payment Add-Ons shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured unless otherwise permitted by federal law.

I. Effective date.

1. The plan effective date shall be October 1, 1981.

2. The adjustment effective date shall be thirty (30) days after notification of the hospital that its reimbursement rate has been changed unless modified by other sections of the plan.

J. Medicare rate. The Medicare rate is the rate established on the basis of allowable cost as defined by applicable Medicare standards and principles of reimbursement (42 CFR part 405) as determined by the servicing fiscal intermediary based on yearly Hospital Cost Reports.

D. Specialty Pediatric hospitals shall not qualify for disproportionate share payments by meeting the state defined requirements. However, they will qualify for disproportionate share payments if they meet the federal requirements as defined in (VI) (A) 1. and (VI) (A) 2.

E. Hospitals shall not send amended cost reports or other data necessary for qualification for disproportionate share classification for purposes of rate reconsideration unless the reports or other necessary data are received within sixty (60) days of the date of the division's notification of the final determination of the rate.

F. Hospital-specific DSH cap. Unless otherwise permitted by federal law, disproportionate share payments shall not exceed one hundred percent (100%) of the unreimbursed cost for Medicaid and the cost of the uninsured. The hospital-specific DSH cap shall be computed using the fourth prior year desk reviewed cost report trended thru the State Fiscal Year. If the sum of disproportionate share payments exceeds the estimated hospital-specific DSH cap, the difference shall be deducted in order as necessary from safety net payment, other disproportionate share lump sum payments, direct Medicaid payments, and if necessary, as a reduced per diem.

XVI. Safety Net Adjustment. A Safety Net Adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph VI.A.4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

A. The safety net adjustment for facilities which meet the requirements in subparagraph VI.A.4.(a) be computed in accordance with the Direct Medicaid Payment calculation described in section XV and the Uninsured Add-Ons calculation in subsection XVII.B. regulation. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

B. The safety net adjustment for facilities which meet the requirements in subparagraph VI.A.4.(b), VI.A.4(c) or VI.A.4.(d) shall be computed in accordance with the Direct Medicaid Payment calculation described in section XV and one hundred percent (100%) of the Uninsured costs calculation described in subsection XVII.B. of this regulation. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

C. The state share of the safety net adjustment for hospitals described in subparagraphs VI.A.4(a) and VI.A.4.(d) shall come from cash subsidy (CS) certified by the hospitals. If the aggregate CS is less than the state match required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

D. Notwithstanding subparagraph B, the safety net adjustment for governmental facilities in state fiscal year 2004 and 2005 shall be up to 175% of unreimbursed Medicaid costs plus 175% of the Uninsured costs calculation described in subsection XVIII.B. subject to the state's disproportionate share allotment and IMD cap. The safety net adjustment shall be on a state fiscal year basis in these years.

XVII. In accordance with state and federal laws regarding reimbursement of unreimbursed Medicaid costs and the costs of services provided to uninsured patients, reimbursement for state fiscal year 2001 (July 1 - June 30) shall be determined as follows:

A. Medicaid Add-Ons for Shortfall

The Medicaid Add-On for the period of July, 1998 to December 31, 1998 will be based on fifty percent (50%) of the unreimbursed Medicaid costs as calculated for SFY 1998.

B. Uninsured Add-Ons

The hospital shall receive eighty-nine percent (89%) of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive ninety percent (90%) of its uninsured costs prorated over the SFY. The uninsured Add-On will include:

1. The Add-On payment for the cost of the uninsured will be based on a three-year average of the fourth, fifth and sixth prior base year cost reports. For any hospital that has both a twelve-month cost report and a partial-year cost report, its base period cost report for that year will be the twelve-month cost report. The Add-On payment for the cost of the uninsured is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the uninsured is then trended to the current year using the trend indices in subsection III.B.. Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment;and

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk review cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days; and

4. The increased costs per day resulting from the utilization adjustment in subsection XV.B. is multiplied by the estimated uninsured days.

5. Notwithstanding any other provision, the Add-on payment for the cost of the uninsured for any public hospital that is not a safety net hospital in state fiscal year 2004 and 2005 shall be up to 175% of the Uninsured costs calculation described in this paragraph subject to the state's disproportionate share allotment and IMD cap. The Add-On payment for public hospitals other than safety net hospitals shall be on a state fiscal year basis in these years.